

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008136

Facility Name: DOBSON PLAZA

Address: 120 DODGE EVANSTON 60202
Number City Zip Code

County: COOK

Telephone Number: (847) 869-7744 Fax # (847) 869-1332

IDPA ID Number: 36-260166801

Date of Initial License for Current Owners: 10/15/66

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) CHARLOTTE KOHN
(Title) ADMINISTRATOR

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DOBSON PLAZA

0008136 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 6/28/01

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>93</u>	Skilled (SNF)	<u>97</u>	<u>34,693</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>97</u>	<u>34,693</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>12</u>		<u>1,393</u>	<u>1,405</u>	8
9	SNF/PED					9
10	ICF	<u>13,450</u>	<u>12,939</u>		<u>26,389</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,462</u>	<u>12,939</u>	<u>1,393</u>	<u>27,794</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 80.11%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒ B/S INCL 2 UNLICENSED BEDS \$32,005

I. On what date did you start providing long term care at this location?

Date started 10/15/66

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 6 and days of care provided 1,393

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	97,147	7,110	44,320	148,577		148,577	0	148,577			1
2	Food Purchase		113,654		113,654	(9,052)	104,602	(800)	103,802			2
3	Housekeeping	38,434	18,307	0	56,741		56,741	0	56,741			3
4	Laundry	38,795	8,093	1,392	48,280		48,280	0	48,280			4
5	Heat and Other Utilities			67,711	67,711		67,711	0	67,711			5
6	Maintenance	87,427	19,166	19,794	126,387		126,387	(1,573)	124,814			6
7	Other (specify):*			3,421	3,421		3,421	0	3,421			7
8	TOTAL General Services	261,803	166,330	136,638	564,771	(9,052)	555,719	(2,373)	553,346			8
	B. Health Care and Programs											
9	Medical Director	0		3,100	3,100		3,100	0	3,100			9
10	Nursing and Medical Records	1,055,388	23,795	225,477	1,304,660		1,304,660	0	1,304,660			10
10a	Therapy	55,875		16,616	72,491		72,491	0	72,491			10a
11	Activities	44,854	14,096	1,129	60,079		60,079	0	60,079			11
12	Social Services	21,040		5,247	26,287		26,287	0	26,287			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	1,177,157	37,891	251,569	1,466,617	0	1,466,617	0	1,466,617			16
	C. General Administration											
17	Administrative	73,685		0	73,685		73,685	0	73,685			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			44,800	44,800		44,800	0	44,800			19
20	Dues, Fees, Subscriptions & Promotions			68,187	68,187		68,187	(58,730)	9,457			20
21	Clerical & General Office Expenses	105,856	8,022	24,744	138,622		138,622	(3,440)	135,182			21
22	Employee Benefits & Payroll Taxes			232,546	232,546	9,052	241,598	0	241,598			22
23	Inservice Training & Education			923	923		923	0	923			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			5,072	5,072		5,072	0	5,072			25
26	Insurance-Prop.Liab.Malpractice			81,111	81,111		81,111	0	81,111			26
27	Other (specify):*			0	0		0	0	0			27
28	TOTAL General Administration	179,541	8,022	457,383	644,946	9,052	653,998	(62,170)	591,828			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,618,501	212,243	845,590	2,676,334	0	2,676,334	(64,543)	2,611,791			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			71,757	71,757		71,757	10,254	82,011			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			232,494	232,494		232,494	(628)	231,866			32
33	Real Estate Taxes			124,442	124,442		124,442	0	124,442			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			1,042	1,042		1,042	0	1,042			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			429,735	429,735	0	429,735	9,626	439,361			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		48,578	612	49,190		49,190	0	49,190			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			52,039	52,039		52,039	0	52,039			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	48,578	52,651	101,229	0	101,229	0	101,229			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,618,501	260,821	1,327,976	3,207,298	0	3,207,298	(54,917)	3,152,381			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,254	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(800)	2		13
14	Non-Care Related Interest	(628)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(117)	20		17
18	Fines and Penalties	(3,440)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(15,911)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(42,702)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(1,573)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,917)		\$ 0	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	0		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 0		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (54,917)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ (1,573)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,573)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA

0008136

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(800)	0	0	0	0	0	0	0	0	0	0	(800)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,573)	0	0	0	0	0	0	0	0	0	0	(1,573)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,373)	0	0	0	0	0	0	0	0	0	0	(2,373)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(58,730)	0	0	0	0	0	0	0	0	0	0	(58,730)	20
21	Clerical & General Office Expenses	(3,440)	0	0	0	0	0	0	0	0	0	0	(3,440)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(62,170)	0	0	0	0	0	0	0	0	0	0	(62,170)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(64,543)	0	0	0	0	0	0	0	0	0	0	(64,543)	29

Summary B

12/31/2001

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
CHARLOTTE KOHN	100	BIRCHWOOD PLAZA, INC	CHICAGO			
		PEDIATRIC REHABILITATION INSTITUTE	CHICAGO			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CHARLOTTE KOHN	ADMINISTRATOR	SUPERVISION	0*	664,323	35	45.00	SALARY	\$ 62,571	17-1	1
2	CYNTHIA KOHN		CLERICAL	0*		40	100.00	" "	28,427	21-1	2
3	HERSHEY WEINGARTEN		CLERICAL	0*		20	100.00	" "	18,427	21-1	3
4	BOAZ KOHN		CLERICAL	6.51*	24,889	14	35.00	" "	13,269	21-1	4
5											5
6											6
7	BY ATTRIBUTION 100% KOHN FAMILY OWNED										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 122,694		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	MID-NORTH FINANCIAL		X	MORTGAGE	\$14,430.00	09/12/96	\$ 3,500,000	\$ 2,393,048	10/01/08	PRIME+	\$ 215,845	1	
2	NATIONAL REPUBLIC BK		X	LINE OF CREDIT	DEMAND	01/21/97	300,000	100,000		PRIME+	7,526	2	
3	NATIONAL REPUBLIC BK		X	AMORTIZED MTG LOAN FEES		01/21/97	49,811	27,311			4,500	3	
4	LEXUS		X	AUTO LOAN	\$1,070.00	04/10/98	52,921	16,275	04/10/03	0.0861	2,575	4	
5												5	
	Working Capital												
6	INSURANCE FINANCING		X	INSUR. FINANCE							1,420	6	
7												7	
8												8	
9	TOTAL Facility Related				\$15,500.00		\$ 3,902,732	\$ 2,536,634			\$ 231,866	9	
	B. Non-Facility Related*												
10	INTEREST ON OVERDRAFT		X								628	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 628	14	
15	TOTALS (line 9+line14)						\$ 3,902,732	\$ 2,536,634			\$ 232,494	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOBSON PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0008136

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 10-25-113-043-0000	NURSING HOME	\$ 121,120.35	\$ 121,120.35
2. 10-25-220-015-0000	NURSING HOME	\$ 1,031.64	\$ 1,031.64
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 122,151.99	\$ 122,151.99

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,536 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	NURSING HOME	7,728		1996		\$ 80,506	
2							
3	TOTALS	7,728				\$ 80,506	

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58		1966	1966	\$ 251,171	\$	35	\$	\$	\$ 251,171	4
5	33			1987	930,705	38,092	40	23,268	(14,824)	358,213	5
6	2			1971	11,147		8-12			11,147	6
7	4			1987	64,011		30	1,067	1,067	1,067	7
8											8
	Improvement Type**										
9	ELECTRICAL & PLUMBING			1976	1,027		8			1,027	9
10	SPRINKLER SYSTEM			1982	9,921		15			9,921	10
11	NURSING OFFICE			1982	891		15			891	11
12	RENOVATE NURSING STATION			1986	5,223		20	261	261	3,675	12
13	LANDSCAPING			1988	6,905		10			6,905	13
14	LAND IMPROVEMENTS - SEWER			1988	5,650		25	226	226	2,900	14
15	LAND IMPROVEMENTS - FENCING			1988	1,878		15	125	125	1,604	15
16	LAND IMPROVEMENTS - PAVING			1988	12,335	1,425	20	617	(808)	7,918	16
17	OUTSIDE SIGN			1988	2,473		12	35	35	2,473	17
18	SPRINKLER SYSTEM			1988	42,241		25	1,690	1,690	21,688	18
19	HEATING, VENTILATION, & A/C			1988	48,620		20	2,431	2,431	31,198	19
20	PLUMBING COMPOSITE			1988	63,062		25	2,522	2,522	32,869	20
21	ELECTRICAL WIRING			1988	115,484		20	5,774	5,774	74,100	21
22	BRICK-ENCLOSED GENERATOR			1989	1,375		25	55	55	633	22
23	FENCE - GENERATOR			1989	480		15	32	32	363	23
24	CATCH BASIN			1989	5,000		10			5,000	24
25	REMODELLING OF ANCILLARY AREAS			1997	534,985	16,179	40	13,374	(2,805)	66,870	25
26	CANOPY SIGN			1999	8,000	205	39	205		487	26
27	ELEVATOR REPAIR			1999	1,990	51	39	51		113	27
28	FIRE DAMPERS / AIR INTAKES			2000	10,515	382	27.5	382		621	28
29	ELEVATOR UPGRADE / AIR INTAKES			2000	28,259	1,028	27.5	1,028		1,157	29
30	ELEVATOR UPGRADE			2001	18,977	546	27.5	546		546	30
31	CARPETING			2001	25,597	8,706	10	1,280	(7,426)	1,003	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,207,922	\$ 66,614		\$ 54,969	\$ (11,645)	\$ 895,560	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 263,093	\$ 308	\$ 20,495	\$ 20,187	5-20 YRS	\$ 235,108	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 263,093	\$ 308	\$ 20,495	\$ 20,187		\$ 235,108	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMIN, BANKING,	'98 LEXUS	1998	\$ 68,441	\$ 1,775	\$ 1,775	\$ 0		\$ 1,775	76
77	ACTIVITIES,MAINT	'95 JEEP		19,087	3,060	4,772	1,712	4 YR	4,772	77
78	PURCHASING						0			78
79							0			79
80	TOTALS			\$ 87,528	\$ 4,835	\$ 6,547	\$ 1,712		\$ 6,547	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,639,049	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,757	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,011	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,254	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,137,215	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY BANKING,	JEEP	\$ 521.00	\$ 1,042	17
18	MAINT, ACTIVITY,				18
19	ETC				19
20					20
21	TOTAL		\$ 521.00	\$ 1,042	21

10. Effective dates of current rental agreement:
- Beginning
- Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$
13.	/2003	\$
14.	/2004	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

HOURS PER AIDE _____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)					
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			612			612	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				30,612		30,612	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					17,966		17,966	13
14	TOTAL			\$		\$ 612	\$ 48,578		\$ 49,190	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 290,538	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	731,225		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,445		6
7	Other Prepaid Expenses	3,120		7
8	Accounts Receivable (owners or related parties)	3,165		8
9	Other(specify): <u>R.E.TAX ESCROW</u>	32,876		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,147,369	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	80,506		13
14	Buildings, at Historical Cost	2,082,284		14
15	Leasehold Improvements, at Historical Cost	160,492		15
16	Equipment, at Historical Cost	353,094		16
17	Accumulated Depreciation (book methods)	(1,172,337)		17
18	Deferred Charges	40,816		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,544,855	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,692,224	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 266,214	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,078		28
29	Short-Term Notes Payable	100,000		29
30	Accrued Salaries Payable	52,353		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,358		31
32	Accrued Real Estate Taxes(Sch.IX-B)	123,370		32
33	Accrued Interest Payable	17,150		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DEFERRED INCOME</u>	160,831		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 728,354	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,275		39
40	Mortgage Payable	2,393,048		40
41	Bonds Payable			41
42	Deferred Compensation	32,669		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,441,992	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,170,346	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (478,122)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,692,224	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (796,692)	1
2	Restatements (describe):		2
3	2000 IL REPLACEMENT TAX	(10,878)	3
4	ROUNDING	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (807,573)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	679,451	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(350,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 329,451	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (478,122)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,755,283	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,755,283	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	29,877	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 29,877	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,000	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	87,511	21
22	Laundry	7,618	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 98,129	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,460	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,460	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,886,749	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	564,771	31
32	Health Care	1,466,617	32
33	General Administration	644,946	33
	B. Capital Expense		
34	Ownership	429,735	34
	C. Ancillary Expense		
35	Special Cost Centers	49,190	35
36	Provider Participation Fee	52,039	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,207,298	40
41	Income before Income Taxes (line 30 minus line 40)**	679,451	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 679,451	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,454	\$ 71,253	\$ 29.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,209	21,118	447,051	21.17	3
4	Licensed Practical Nurses	2,234	2,356	47,275	20.07	4
5	Nurse Aides & Orderlies	43,277	46,588	420,787	9.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,102	3,427	55,875	16.30	8
9	Activity Director	2,095	2,375	30,373	12.79	9
10	Activity Assistants	1,684	1,924	14,481	7.53	10
11	Social Service Workers	1,118	1,196	21,040	17.59	11
12	Dietician					12
13	Food Service Supervisor	918	940	15,691	16.69	13
14	Head Cook	5,376	6,092	52,209	8.57	14
15	Cook Helpers/Assistants	4,370	4,557	29,247	6.42	15
16	Dishwashers					16
17	Maintenance Workers	9,860	10,776	87,427	8.11	17
18	Housekeepers	6,043	6,361	38,434	6.04	18
19	Laundry	5,165	5,664	38,795	6.85	19
20	Administrator	2,560	2,592	73,685	28.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,387	8,764	105,856	12.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,160	4,871	69,022	14.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,638	132,055	\$ 1,618,501 *	\$ 12.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 44,320	1-3	35
36	Medical Director	O	3,100	9-3	36
37	Medical Records Consultant	N	4,729	10-3	37
38	Nurse Consultant	T	100	10-3	38
39	Pharmacist Consultant	H	2,150	10-3	39
40	Physical Therapy Consultant	L	15,719	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	175	10a-3	43
44	Activity Consultant	E	329	11-3	44
45	Social Service Consultant	E	5,247	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 75,869		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,561	\$ 102,618		50
51	Licensed Practical Nurses				51
52	Nurse Aides	12,055	114,522		52
53	TOTAL (lines 50 - 52)	16,616	\$ 217,140		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2000	\$ 2,721	3	\$	\$	\$ 907	\$ 907	\$ 907	\$	\$	\$	\$
2	PAINT/DECORATING	2001	2,976	3				496	992	992	496		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,697		\$	\$	\$ 907	\$ 1,403	\$ 1,899	\$ 992	\$ 496	\$	\$

Facility Name & ID Number DOBSON PLAZA

0008136

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 52,039
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 9,052 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	44,320
	REPAIRS & MAINTENANCE	0
		0
		44,320
3	HOUSEKEEPING	
		0
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,392
		0
		1,392
5	HEAT & OTHER UTILITIES	
	GAS HEAT	19,390
	ELECTRICITY	24,432
	WATER	23,889
	CABLE TV - LOBBY	0
		0
		67,711
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,722
	PAINTING & DECORATING	2,976
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,435
	ELEVATOR MAINTENANCE & REPAIR	1,485
	OUTSIDE LABOR	2,374
	EXTERMINATING SERVICE	2,496
	FIRE SERVICE	1,306
		0
		0
		0
		19,794
7	OTHER	
	SCAVENGER	3,421
	SECURITY SERVICE	0
		3,421
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	3,100
		3,100

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	217,140
	LABORATORY & XRAY EXPENSE	1,358
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,729
	PHARMACY CONSULTANT XVIII B 39-2	2,150
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	100
		0
		0
		225,477
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	722
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	THERAPY CONTRACT SERVICES	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	15,719
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	175
		16,616
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	329
	CLERGY	800
		1,129
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	5,247
		0
		5,247
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B0	0
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C3,886	
	ADMINISTRATIVE CONSULTANTS	XIX C0	
	PROFESSIONAL FEES	XIX C40,914	
		0	44,800
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F15,911	
	EMPLOYEE WANT ADS	XIX F1,543	
	CONTRIBUTIONS	VI 20 XIX F0	
	DUES & SUBSCRIPTIONS	XIX F45	
	LICENSES & PERMITS	XIX F7,869	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F42,702	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F117	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F0	68,187
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES	557	
	EQUIPMENT REPAIR & MAINTENANCE	1,731	
	OUTSIDE CLERICAL SERVICES	212	
	PENALTIES / OVERDRAFT CHARGES	VI 183,440	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	18,804	
	MESSENGER SERVICE	0	
		0	24,744

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D123,816	
	UNEMPLOYMENT COMPENSATION	XIX D9,073	
	WORKERS COMPENSATION INSURANC	XIX D22,236	
	HOSPITALIZATION INSURANCE	XIX D75,302	
	EMPLOYEE BENEFITS - OTHER	XIX D2,119	
	EMPLOYEE PHYSICAL EXAMS	XIX D0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D0	
	PENSION/PROFIT SHARING PLANS	XIX D0	
	CHICAGO HEAD TAX	XIX D0	232,546
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	923	923
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G0	
	TRAVEL	XIX G0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	5,072	5,072
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	81,111	81,111
27	OTHER		
	BAD DEBTS	VI 240	
		0	0

GRAND TOTAL COLUMN 3 OTHER

845,590

DOBSON PLAZA
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	113,654	PATIENT MEALS	83382
LESS SALES TAX	(800)	ADD EMPLOYEE MEALS	7300
	-----		-----
NET FOOD	112,854	TOTAL MEALS/YEAR	90682
TOTAL PATIENT CENSUS	27,794	NET FOOD	112854
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	90682

TOTAL PATIENT MEALS	83382	COST PER MEAL	1.24
		TIME EMPLOYEE MEALS	7300
ADD # EMPLOYEE MEALS/DAY	20		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	9052
	-----		=====
TOTAL EMPLOYEE MEALS	7300		